qrulepubliccomments

From: Charles Ferling [cferling@omniairintl.com]
Sent: Saturday, February 18, 2006 4:42 PM
To: qrulepubliccomments
Subject: ATTN: Q Rule
Attachments: Centers for Disease Control and Prevention.doc

Pleas find, attached, comments relative to the NPRM for Control of Communicable Diseases.

Centers for Disease Control and Prevention
Division of Global Migration and Quarantine
1600 Clifton Road, NE (E03)
Atlanta, GA 30333 USA

ATTN: Q Rule Comments

16 February 2006

To Whom It May Concern:

Omni Air International is a U.S. certificated Part 121 air carrier, operating large commercial aircraft in non-scheduled interstate and international transportation of both passengers and goods. Omni serves commercial and U.S. government customers over routes entirely within the United States, between the United States and international locations, and over routes entirely outside the United States. As such, we share the Centers for Disease Control and Prevention's (CDC's) sense of urgency and desire to implement effective measures to control the introduction, transmission and spread of communicable diseases. We understand the complexity of the issues addressed by the Notice of Proposed Rulemaking (NPRM).

We very much appreciate the comprehensive effort undertaken to completely re-write Parts 70 and 71 of the Code of Federal Regulations, Title 42. The addition of provisions for screening to detect ill persons, the expansion of definitions, and the detailed processes for provisional quarantine and quarantine represent significant and beneficial measures for the protection of public health. We fully support the expanded definition of an ill person to include descriptive terms that are overt and commonly understood.

We note with concern, though, that the CDC appear to have focused almost exclusively on air transportation as the sole vector for the introduction of communicable diseases in interstate transportation. In the NPRM, the CDC have (perhaps inadvertently) relieved the master of a vessel or the person in charge of any conveyance engaged in interstate traffic of any notification requirement of death or an ill passenger. We're very much concerned that most of the proposed rule is exclusively applicable to air carriers.

In the preamble, the CDC have acknowledged that air carriers "*must comply with myriad regulatory requirements relating to safety, immigration, and homeland security*" and that they received "***significant cooperation from the airlines***" in response to the SARS crisis in 2002 – even in the absence of additional regulation. Unfortunately CDC have not recognized that, just as they were exposed to the clear limitations in the **then** current system, the air travel industry also took significant lessons away from that crisis. Significant changes have been made in the air travel industry that may preempt some of the assumptions on which the NPRM appears to have been based – most notably the efforts by the air travel industry and the U.S. Department of Homeland Security to standardize collection of data on domestic as well as international passengers.

Before moving to the specifics of the individual proposed rules, we would respectfully request that the CDC clarify their intent in apparently restricting the most onerous of the new rules to airlines. It would appear to us that the effort to prevent the introduction, transmission and spread of communicable diseases and the interest of public health would be best served by a universal system of controls applicable to all modes of conveyance, including, but not limited to rail, water-borne vessels, and omnibus "over-the-road" modes. The air travel industry has enjoyed a great level of success in assuring our passengers' safety through comprehensive programs to assure cabin air quality, food safety, drinking water quality and hygienic facilities. While we recognize the significant impact that the speed of air travel can have on the possible spread of communicable diseases, we feel that the speed of travel and the extra-ordinary measures necessary to ensure our passengers' safety and comfort also helps limit each passenger's potential exposure to a communicable disease.

In just around two hours, an air passenger can safely travel from New York to Chicago in a carefully controlled environment and provided be in-flight service by highly competent and trained medical first responders. By rail or bus, a passenger may be exposed to other passengers with communicable diseases for over 18 hours to cover the same distance. Similarly, the number of passengers aboard even the largest modern airliner palls by comparison to today's largest cruise ships.

The CDC's plan to collect passenger data in order to facilitate contact with potentially exposed passengers would seem equally, if not more effective in the slower and vastly larger single vessel modes.

§ 70.1 Scope and definitions – We **support** the changes to add the purpose of the rule and to expand and revise the definition of key terms. We find the expanded definition of an ill person particularly clear, concise and appropriate to the risks faced. While we understand the definition of *military service*, we would ask that the CDC either define *military carrier* or adopt definition of *public use aircraft* contained elsewhere in the Code of Federal Regulations.

The air travel industry would be particularly well served if the CDC would clarify in the regulation if their intent is to apply the requirements of subsequent sections to commercial whole-aircraft charters to military services or other U.S. Government agencies.

We also suggest that the CDC look carefully at their definition of flight information and consider deleting from that definition "*seat number for any passenger or crewmember, arrival gate and arriving terminal*". These data are not relevant under the data collection scheme required in subsequent sections. Crewmembers' seats are not numbered and a passenger's seat assignment at check-in is not necessarily reflective of their actual seating *en route*. Its also hard to comprehend how the CDC intends to use terminal and gate information 60 days and 12 hours after flight arrival when all data relative to flights arriving at that same terminal will likely no loinger be available.

§ 70.2 Report of death or illness on board flights – We **support** the change to notification requirements from the local health authority to a single point of contact. We **oppose** the limitation of notification requirements to airlines only. We believe that the interests of public health are best served by requiring all carriers to report and deaths or ill persons on board to the Director.

§ 70.3 Written plan for reporting of deaths or illness on board flights and designating of an airline agent – We **oppose** the rule in it's entirety. The air travel industry has consistently demonstrated it's intent and ability to comply with notification requirements as evidenced by the almost nonexistent number of enforcement actions on record for the existing regulations. There is little to be gained by requiring airlines to duplicate language already present in their required system of manuals to a separate manual that is submitted, but not necessarily reviewed, accepted, or approved by the CDC.

We oppose the requirement to require, through regulation, the assignment of a point-of-contact to the CDC. We believe that the CDC should work with the U.S. Federal Aviation Administration to access current contact information for the positions already required by regulation, *i.e.* Director of Safety, or Director of Operations. Additional designation of a point-of-contact to CDC is a step

that is likely to be overlooked or handled through a group disposal to ensure regulatory compliance, whereas the positions required by 14 CFR Part 119 are a condition of the air carrier's operating certificate and are kept current in near real time.

We believe CDC would be well served to establish a voluntary "web-board" service with e-mail notification, similar to that used by the Transportation Security Administration, to facilitate communication in lieu of a regulatory requirement for a point-of-contact.

If the CDC feel that the designation of a point of contact and another written program are critical to its ability to protect public health, we respectfully suggest that the rule be applied to all modes of transportation.

§ 70.4 Passenger information – We **strongly oppose** the rule in it's entirety. The CDC correctly cites the requirements of the Department of Homeland Security for data collection on passengers traveling to, from or over the territory of the United States. They do not, however, recognize the DHS requirement for similar data on domestic flights or the difficulty DHS have had in establishing an efficient, functional system to collect, vet and store these data. We strongly urge CDC to work with their associates at DHS to understand the scope and complexity of their proposed rule and to work with the Department to use those data already provided by air carriers to the United States Government. To require air carriers to collect, store and transmit a similar subset of data to yet another agency within the same Government is onerous and inconsistent with the industry's goal to safely simplify passenger travel.

Further, in their preamble, CDC cite studies showing that passengers would be willing provide the data, but disregard the fact that, for international air travel, industry already collect most of the voluntary data required by the rule. CDC also recognize, based on their first-hand experience, that the voluntary data provided by passengers on international flights has often been illegible. Its unreasonable to expect that the same information provided by a passenger for a domestic flight would be any more legible or to expect air carriers to convert these data to an electronic format with any higher degree of accuracy.

We oppose the requirement to solicit information from the "*head of household if that passenger is a minor*". CDC have not defined a "minor" passenger and carriers' application of the term "minor" may vary between carriers and across regions served by any one carrier. The rule, as written, ignores standard practices within industry and requires a check-in agent to use a definition from the tax code (head of household) and an unknown determinant (at what age is a passenger no longer a minor) to establish the person from whom the carrier must request data.

We do not believe the CDC fully understand how passengers reserve seats and travel by air, nor how air carriers collect and store passenger name records. Something as seemingly simple as collecting "*full name*" data becomes enormously complex given the American propensity to use nicknames, alternate spellings, *etc*. The rule does not specify the source of "full name" data, making it near impossible for a carrier or passenger to understand the requirement. In our own case, as an example, between one and five percent of our employees have government-issued photo identification media with different names on them. This becomes particularly apparent when an person has a passport issued outside the United States using the local convention for name order and spelling and has another document, like a driver's license or resident alien card, deleting a portion of their "full name" or using an alternate spelling. As CDC propose that airlines collect passport or travel documents numbers and issuing country or organization for purely domestic travel, they are perhaps aware of some upcoming rule changes that would facilitate our ability to collect these data.

Given industry's and Government's experience in the two years its taken in an attempt to establish a scheme under which to collect and vet similar data at DHS, it is unrealistic to expect that air carriers will be able to effect the electronic transfer of data to CDC any time in the foreseeable future.

CDC also demonstrate a misunderstanding common to that experienced at DHS regarding how air carrier seats are sold. The requirement for airlines to inform passengers of the purpose of the collection of information "*at the time passengers arrange their travel*" assumes passengers

always make their travel arrangements with an airline. This ignores the fact that many passengers arrange travel through consolidators, travel agents, and others that are not regulated and not directly associated to the carrier. If fact, our passengers **never** make travel arrangements directly with us. Their first contact with a direct carrier employee is most often when the flight attendant meets them at the doors during boarding.

We **oppose** the requirement to keep passenger manifest data beyond the 30 days currently required by U.S. FAA regulation.

Again, if CDC believe this rule necessary to protect the interests of public health, the rule should be universally applied to all modes.

§ 70.5 Written plan for passenger information and designation of an airline agent – We **oppose** this rule for the same reasons cited under § 70.3, above. The air travel industry has demonstrated its intent and ability to collect essential information without the necessity of another written program collecting dust on a shelf. Air carriers already regularly test their ability to compile passenger emergency notification data and transmit those data to a number of end users. A redundant annual validation to another office within the United States Government is not a productive use of resources.

If left in the final rule in the interest of public health, this section should be applicable to all modes of transportation.

§ 70.6 Travel permits – We **support** the rule, but ask that CDC carefully craft language that permits, but does not require air carrier to transport passengers with a travel permit and allows that air carrier to recover from the passenger the cost of measures required by the Director.

§ 70.7 Responsibility with respect to minors, wards, and patients – We **support** the rule as written.

§ 70.8 Military services – We **support** the rule, but ask CDC to clarify if their intent is to exempt commercial airlift providers of whole-aircraft charters to military services and to consider exemption of whole-aircraft charters to any agency of the United States Government.

§ 70.9 Vaccination clinics – We **support** the rule as written.

§ 70.10 Establishment of institutions, hospitals and stations - We **support** the rule and applaud CDC for their recent efforts in this area.

§ 70.11 Sanitary measures - We **support** the rule, but encourage CDC to work closely with the U.S. FAA, aircraft manufacturers and air carriers to fully understand the pre-emptive authority of the FAA in matters relative to aviation safety. Under regulation, air carriers are only permitted to use products (including those for disinfection, disinsectization, and disinfestation,) that have been approved under the their programs for ensuring the airworthiness of aircraft. Unfortunately, we have seen several cases in he recent past where well-meaning health authorities have applied highly corrosive, or otherwise incompatible products to aircraft interior or exterior surfaces without the knowledge or consent of the air carrier.

§ 70.12 through § 70.31 – We **support** the rules as written and wish to particularly support pre-departure screenings to detect ill passengers (§ 70.13) under the authority of the Director.

§ 71.1 Scope and definitions – We **support** the change, keeping to mind the same remarks to § 70.1, above.

§ 71.2 through § 71.5 – We **support** the rules as written.

§ 71.6 Report of death or illness on board flights – We **support** the rule, but ask CDC to consider removing reference to a written plan.

§ 71.7 Written plan for reporting of deaths or illness on board flights and designation of an airline agent – We **oppose** this rule for the reasons cited in § 70.3, above.

§ 71.8 and § 71.9 – While these rules are outside our core competency, we would suggest that CDC consider trans-boarder surface modes, as well as shiplines.

§ 71.10 Passenger information – We **strongly oppose** this rule for the reasons cited in § 70.4, above.

§ 71.11 Passenger information – We **strongly oppose** this rule for the reasons cited in § 70.5, above.

§ 71.12 through § 71.56 – We generally **support** the rules, but again caution CDC regarding the need for close coordination between carriers, aircraft manufacturers, and the FAA (or other competent national authority) before compelling the use of any particular product.

We believe that the value of passenger screening and the increased number of facilities available to address public health concerns in support of international air travel cannot be overstated. CDC are to be commended for their outstanding and ongoing efforts.

Due to the complex nature of the data collection and reporting requirements, we cannot concur with the CDC's cost analysis (beyond agreeing that this is a Significant Regulatory Action which potentially will adversely impact a sector of the economy, productivity, or jobs). We respectfully request CDC extend the comment period an additional 60 days to permit a more thorough cost analysis.

Additionally, we note that CDC do not appear to have published its evaluation of International Compatibility as part of the NPRM. We encourage CDC to consider World Health Organisation (WHO) and International Civil Aviation Organisation (ICAO) Conventions and Annexes and possible differences to those or other international agreements. We firmly believe that the interests of public health globally are best served by universal and seamless controls. While the definition of an ill person, for example, may be more restrictive than that used by ICAO, we believe that it is also more practical and effective in today's environment. We encourage CDC to work with their international counterparts to harmonize regulation globally.

Respectfully,

s / Charles Ferling, *Director of Safety and Security*
Omni Air International
P.O. Box 582527
Tulsa, OK 74158 USA